

**Minimum Standards for the Recording of Risk Assessment and
Safety/Management Plans in Adult, Learning Disability, CHYPS & Forensic
Healthcare
(May 2020)**

These standards apply to all Professional Groups.

Contents

Section1 - Risk Assessment	3
Section 2 - Completion of Risk Assessment Universal	4
Section 3 - My Care & Safety Plan	4
Section 4 - Multi-disciplinary Risk Assessment.....	4
Section 5 - Reviewing / updating the Universal Risk Assessment	4
Section 6 - Risk Events.....	5

Section1 - Risk Assessment

- **All** Risk recording must be completed on the Carenotes **Risk Assessment Universal** Form; these can be found in the Risk Tab. (*please see screen shots below*). As you will see both of these templates are currently found under one tab (*second screen shot*).
- For Psychiatrists working as the Lead Practitioner in out-patient clinics the risk assessment and safety plan should be documented and communicated in the standard GP letter which should be completed and sent out within 2 weeks. A contemporaneous entry in the Carenotes clinical notes section must be made on the day of review which should include a brief statement of risk and any major changes to the care plan. Once the GP letter has been completed and uploaded into correspondence in Carenotes, the risk management tab of the patient record should be opened and an entry made in the first field directing the reader to the labelled GP letter. If the presentation is complex or particularly risky, the Psychiatrist may choose to complete the universal risk assessment in Carenotes and involve the Multi-Disciplinary Team in this process.
- When there are concerns regarding significant risks to self or specific others, an alert must be generated. An alert is generated via the demographics tab by clicking on the drop down box of options under the 'create a new' tab.
- Please **do not** upload risk assessment documents on to Carenotes (other than for an onward referral to ATS if you work in Health in Mind or completed HCR 20 V3 and RSVP Forms).
- All adults must have a Risk Screening as a minimum (except in the context of triage and a telephone contact in which further information is required that is not considered part of a clinical assessment and/or risk related).
- The **Risk Assessment Universal** form **must** be completed at the initial assessment (Face to Face or by Phone).
- The risk assessment **must** be reviewed and updated as a minimum every 12 months or whenever there is a change in clinical presentation or circumstances.

Section 2 - Completion of Risk Assessment Universal

- If a new risk assessment is needed this should be created as a new form from the risk management tab of the patient record.
- When completing the assessment you must:
 - Involve service user/carer/family wherever possible (think *Triangle of Care*)
 - Complete all sections, including succinct chronology of risk events, and identify risk and protective factors level of risk
 - Use 5 P's model for risk formulation
- Once risk is assessed and recorded, please save and **confirm**. If it is not confirmed it will not be possible to re-plan.

Section 3 - My Care & Safety Plan

- Now complete the My Care & Safety Plan within the Care plan form
- This should ideally include a collaborative relapse prevention plan
- This needs to outline the crisis plan.
- Once completed press confirm

Section 4 - Multi-disciplinary Risk Assessment

- MDT input into the Risk Assessment Universal form should be sought whenever there are complex high risk situations. The management/care & safety plan would usually involve more than one clinician in the team or multiple agencies

Section 5 - Reviewing / updating the Universal Risk Assessment

- All Risk Assessments and Management plans must be reviewed as a minimum every 12 months after which they will be out of date.
- The risk assessment **must** also be reviewed / updated when:
 - There is any new information, or a change in the service user's presentation or circumstances which could potentially impact on risk
 - Reviewing risk and care & safety plans at CPA reviews (e.g. 6 months).
 - Service user presents at A&E or requires crisis intervention activity
 - Admitted or discharged from hospital or custody (this includes when a patient is transferred between wards/hospitals)
- If on review there has been no change, the risk assessment should be **re-planned** and a statement added confirming that there has been no change to the identified risks and safety plan.

To start review or update:

- Open the current risk assessment under the risk management tab
- Click **'Edit'** at the top of the current risk assessment screen
- Then click **'Replan'**. Risk assessments must always be replanned rather than a new one created to prevent the loss of key historical risk information (that may not be included on a new assessment if it is not known).
- Once updated with all relevant changes please **save** and then **confirm**. If the risk assessment is not confirmed it means that it can not be re-planned.

Section 6 - Risk Events

- A separate 'All – Risk Event' form is available under the 'Risk Management' tab where individual risk events can be added.
- Risk events are also viewable under the summary button at the top of the screen.
- Risk Events that have been recorded on Carenotes will populate automatically in the table below when the form is completed electronically.

This is what the risk events look like in a risk assessment form:

RISK EVENTS							
You may add a new 'Risk Event' using the button below, or 'Create a new' Risk Event from the 'Risk Management' tab.							
Chronology of Risk Events							
To 'Confirm' or 'Edit' any of these Events, please click on the 'Risk Event' number below.							
Risk Event	Date of Incident/Event	Date Type	Risk Type	Context	Factors and Triggers	Outcome	Service User Perspective
1	23/01/2017	Actual	Generic Risk Event	Took overdose at his home whilst under influence of alcohol. Had left a note and was found by chance when ex-partner returned to flat	Notification of redundancy	Referral to crisis team	Service user in agreement with referral.

This is what risk events look like under the summary button at the top of the patient record

Risk Events							
To 'Confirm' or 'Edit' any of these Events, please go to the Risk Event or Risk Assessment documents.							
Risk Event	Date of Incident/Event	Date Type	Risk Type	Context	Factors and Triggers	Outcome	Service User Perspective
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